BENEFICIARY ADDRESS AND MARITAL STATUS DESIGNATION AND CHANGE FORM

Supporting Directive BUPERSINST 5300.10A

PRIVACY ACT STATEMENT: SECTION 5 OF THE UNITED STATES CODE 552A(B), AUTHORIZES COLLECTION OF THIS INFORMATION. THE INFORMATIONYOU SUPPLY WILL BE USED TO MANAGE AND ADMINISTER BENEFIT PROGRAMS FOR NON-APPROPRIATED FUND (NAF) DEPARTMENT OF THE NAVY PERSONNEL. COLLECTION OF THIS INFORMATION IS AUTHORIZED BY EXECUTIVE ORDER 9397 AND 5 U.S.C. SECTION 301. FURNISHING THE INFORMATIONON THIS FORM, INCLUDING YOUR SOCIAL SECURITY NUMBER AND OTHER PERSONAL INFORMATION, IS VOLUNTARY. HOWEVER, FAILURE TO PROVIDE THE INFORMATION MAY DELAY OR PREVENT ADMINISTRATION OF BENEFIT FUNCTIONS. NAME: SEX: MALE FEMALE STREET ADDRESS: CITY, STATE, ZIP CODE: ACTIVITY NAME AND LOCATION: DATE OF BIRTH (MM/DD/YYYY): SSN: MARTIAL STATUS: SINGLE OR LEGALLY SEPARATED ☐ MARRIED ☐ DIVORCED A. LIFE INSURANCE: CURRENT COVERAGE: BASIC LIFE YES □ NO OPTION A (1 TIME) YES NO OPTION B (2 TIMES) YES NO NAME RELATIONSHIP **ADDRESS** SSN DOB PERCENT B. SAVINGS PLAN: CURRENT PARTICIPATION PERCENT (ENTER ZERO IF NOT PARTICIPATING) SAVINGS PLAN (401K) BENEFICIARY) NAME RELATIONSHIP ADDRESS SSN DOB PERCENT C. RETIREMENT PLAN: CURRENTLY PARTICIPATING ☐ YES ☐ NO RETIREMENT PLAN BENEFICIARY NAME RELATIONSHIP ADDRESS SSN DOB PERCENT WERE ADDITIONAL PAGES ADDED TO THIS FORM? TYES NO IF YES, HOW MANY? EMPLOYEE'S SIGNATURE: D. UNPAID COMPENSATION BENEFICIARY: RELATIONSHIP ADDESSS SSN DOB PERCENT PAGE 2 MUST BE COMPLETED

BENEFICIARY ADDRESS AND MARITAL STATUS DESIGNATION AND CHANGE FORM (CONTINUED)

Supporting Directive BUPERSINST 5300 10A

| | | | | Supporting Directive | BUPERSINST 5300.10A |
|--|---------------|-------------|--------|----------------------|---------------------|
| E. SPOUSE WAIVER: IF YOU ARE MARRIED AND HAVE <u>NOT</u> ELECTED YOUR SPOUSE AS THE PRIMARY BENEFICIARY ON ALL OF THE ABOVE PLEASE HAVE YOUR SPOUSE PROVIDE CONSENT BELOW. | | | | | |
| SPOUSAL CONSENT: I UNDERSTAND THAT I HAVE A RIGHT TO BE DESIGNATED AS THE PRIMARY BENEFICIARY IN ALL OF THE ABOVE. I CONSENT TO WAIVE THAT RIGHT IN ACCORDANCE WITH THE BENEFICIARY DESIGNATIONS SET FORTH ABOVE. I FURTHER UNDERSTAND AND ACKNOWLEDGE THAT IF I SIGN THIS FORM THAT I WILL NOT RECEIVE ANY BENEFITS OTHER THAN THOSE DESIGNATED ABOVE IF ANY. | | | | | |
| SPOUSE SIGNATURE | | DATE | | | |
| F. EMERGENCY CONTACT INFORMATION: THE FOLLOWING INDIVIDUAL(S) ARE TO BE CONTACTED IN CASE OF EMERGENCY. | | | | | |
| NAME | STREET ADDESS | CITY, STATE | ' 7TD | HOME PHONE | WORK PHONE |
| PRIMARY | SIREI ADDESS | CIII, SIRIE | 1, ZIE | HOME PHONE | WORK PHONE |
| SECONDARY | | | | | |
| G. THE INFORMATION ON THIS FORM IS: | | | | | |
| If a change of address, what was the old address: STREET ADDRESS CITY, STATE, ZIP | | | | | |
| H. EMPLOYEE SIGNATURE: I UNDERSTAND THAT THIS DESIGNATION SUPERSEDES ALL PREVIOUS DESIGNATIONS AND THAT IF I HAVE LISTED A MINOR AS BENEFICIARY I HAVE MADE ANY LEGAL ESTATE ARRANGEMENTS REQUIRED BY LAW FOR THIS TO BE ACCEPTABLE. I HEREBY CERTIFY THAT ALL STATEMENTS MADE ON THIS ELECTION ARE TRUE TO THE BEST OF MY KNOWLEDGE. | | | | | |
| EMPLOYEE SIGNATURE DATE | | | | | |
| I. WITNESSES: THIS FORM IS VALID ONLY IF WITNESSED BY TWO PERSONS. THE WITNESSES MUST BE AGE 21 OR OLDER. (A WITNESS IS NOT ELIGIBLE TO RECEIVE PAYMENT AS A BENEFICIARY) | | | | | |
| WE THE UNDERSIGNED, CERTIFY THAT THIS STATEMENT WAS SIGNED IN OUR PRESENCE. | | | | | |
| WITNESS SIGNA | TURE STREET | ADDRESS | CITY, | STATE, ZIP | DATE |
| | | | | | |
| | | | | | |
| J. EMPLOYING PERSONNEL OFFICE CERTIFICATION: I HAVE REVIEWED THE DESIGNATION AND CERTIFY THAT THE DESIGNATED SHARES TOTAL 100% AND THAT NO WITNESSES ARE DESIGNATED AS BENEFICIARY. | | | | | |
| DATE RECEIVED: SIGNATURE: | | | | | |
| DATE FILED IN OPF: | | | | | |
| (ALL SECTIONS OF THE FORM SHALL BE COMPLETED FOR EVERYTHING | | | | | |